Michigan Department of Community Health
Jennifer M. Granholm, Governor
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Michigan Department of Community Health
Medical Services Administration

APC Workgroup Meeting
May 2, 2006 - 9-11 a.m. @ MPHI
Meeting Minutes

I. Welcome & Agenda Review

II. Initial Estimate of OPPS Implementation – Steve Ireland

1Q 2005 FFS data used. Reviewed Encounter Data to see if appropriate to include as well as data from hospitals to get significant sample to use for the analysis. Data was not complete enough to include – Encounter data is missing financial information (which is not required) and supplemental data was not significant enough in volume to do any kind of extrapolation on the data.

Therefore, MDCH was limited to using the FFS data which has some inherent problems with transferring it to the OPPS methodology. Problems included there are codes which Medicaid covers that Medicare does not – specifically those with pay status E or B under the OPPS. MDCH was able to crosswalk some of these codes to other applicable codes that are payable under OPPS. In other situations we were able to use the "Wrap around codes"to get to payable codes. We have identified approximately 50 codes that we can use at this point in time to add to the estimates. There were a number of codes that we could not do a wrap around and we had to take our best guess at which code would apply.

Worked through individual claims to convert the codes to applicable crosswalk codes to move forward with the analysis. It was found that in these cases with crosswalking, payment was about 80% of what Medicaid actually paid, so MDCH extrapolated that out to all Pay Status B and E codes as well as the invalid HCPCs lines. It's not the preferred method, but MDCH is limited to the current data set and codes that have been billed under the current methodology. The majority of these claims were for situations where Medicaid currently does not require a HCPC and pays based on the Rev Code provided (dialysis, etc.)

MDCH realizes that there is a volume of these claims in the data set, but continues to make attempts to analyze the impact of the implementation of the OPPS. MDCH has initially set the conversion factor at 60%, a wage index was not applied and the outlier threshold was set at $1175 – should've been at $1250 – which will be a minor difference and corrected as part of the updated analysis on Q2 2005 data. Discount factors were set at 50% for multiple surgical procedures and the non-urban physician fee schedules were used.

OPH Medicaid Cost to Charge ratios were applied/used for this analysis – and for CORFs/ESRDs – a default CCR was utilized. Total reimbursement was limited to charges for purposes of this analysis. This is something that will not be used under the revised analysis as proposed policy will only apply the limitation of charges on a line by line basis for fee schedule items which follows Medicare's OPPS methodology.

All facilities are included in this analysis without any exceptions. The ambulance fee schedules are included, however there is no claims data included in the financial impact. MDCH intends to include ambulance HCPCs in it's Wrap around code lists and allow OPH based/owned ambulance providers to bill under the OPPS. The reimbursement rates will be identical to the current PT18/Ambulance providers fee schedule.

16% of the Rejected claims population was also included in this analysis to account for claims which are rejected under current methodology that may/can be paid under the proposed OPPS. These claims charges accounted for an approximate 1.2% of total charges and this 1.2% was used to increase the overall payments across all hospitals.

Individual hospital impacts range from as low as 75% of original payment up to 118% of current payments for facilities. The average effect was about 103% - but the total overall impact across all hospitals when applying the 60% reduction factor is about 97%.

MDCH has been asked if it is anticipated that this 97% will reach 100% for total budget neutrality and the response is no. After reviewing the FFS data and understanding the assumptions and issues with the data, there are significant concerns regarding additional codes and payments which will apply under the proposed OPPS and MDCH has to account/allow for that in some manner. The majority of those codes relate to the raising of the $75 daily lab limit, Surgical procedure codes that are not being reported, ambulance claims and general codes that are not currently being billed as the payment is currently based on the Revenue Codes. Outliers on the data analysis were in alignment with Medicare's current experience with outliers –approx 2.5% of total payments were for outliers .

Questions/Discussion:

1) Question regarding using Wage Index impact - MDCH does intend to do an impact analysis of the Wage index on these numbers but it will not be complete before the May 25th comment closing period. MDCH will provide a worksheet which will help providers use the numbers in the Appendix A of the Estimate Analysis to gain an overall high level understanding of how applying the Wage index will impact their numbers in aggregate. Note that the wage index only applies to the 60% labor portion of the APC/OPPS weight (the other 40% is not included in the wage index calculation).

2) Cost to Charge Ratio - MDCH will be using the Medicaid hospital Specific OPH Cost to charge ratios which are rebased the same time the IPH CCR are done. The most recent rebasing was in April '05 and they were subject to appeals and are now final.

3) Please clarify the state wide impact and budget neutrality with regards to the Dual Eligibles savings which were intended/reported several years ago. The implementation of the OPPS will be budget neutral for the FFS non-dual population. The intent of the OPPS with regards to budgetary savings only applies to the dual eligible population.

4) Will data files used for this analysis be available for hospitals to review? Yes, providers can send a request to the APC project e-mail address to request their hospital specific claims data file for the 1Q 2005 claims which were used for this analysis. The file will be forwarded to you in a password protected Excel file.

5) Question regarding limitation of charges for the entire claim versus limitation of charges on an individual claim line basis in this analysis. For this analysis, charges were limited on the total claim basis, which was the original intent. For future analysis, charges will be limited only for fee schedule or wrap around line items – not for APC line items or for total claim charges. The impact of changing this methodology on the data analysis will probably be less than 1% as most likely, the charges in total for the claim are all reported and accounted for and most often exceed the total OPPS payment.

6) Question regarding charges on the Surgery under current billing methodology. Hospitals report total charges and a single HCPC on the first surgery line and quantity is based on time units. Subsequent lines may be billed with a HCPC with $0 charges and this may be impacting the reimbursement under OPPS and the hospitals overall impact analysis. Under OPPS, each procedure would be billed on an individual line with corresponding charges and quantity of service – not time – is usually reported. These differences in billing methodologies may have an impact on the overall estimate of payments. MDCH did not attempt to prorate or accommodate for this but will go back and review the $0 charge lines to ensure that an APC payment was assigned for the subsequent lines. These differences in billing (along with the understanding that modifiers are not currently recognized for bilateral/multiple surgeries) have been noted and are another reason why the overall budget neutrality factor is at 97% rather than 100% - to accommodate for the unknown impacts of differences in coding from the current methodology to the proposed OPPS.

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III. Proposed Policy Bulletin Review & Comments – Kathy Whited

Proposed Policy Bulletin has been out for a month now, comments are due by May 25, 2006. MDCH is requesting those comments/concerns to be raised prior to May 25th so we can prepare and respond in a timely manner with the final policy document. MDCH sent an e-mail to workgroup participants yesterday (5/1/06) with a draft list of MDCH's Wrap Around codes as well as Type of Bill information under the proposed OPPS.

Wrap around codes are those codes that are not covered under Medicare's OPPS that we have currently identified as necessary coverage items under MI Medicaid. We do not have any Dialysis included yet as MDCH is reviewing these claims/billing scenarios and we have not included any R1 status indicators for the MI Medicaid non-covered codes which Medicare does cover under their OPPS (these will be few in number). The draft list of the Wrap Around Codes will be posted to the OPPS website for further review.

Type of Bills – MDCH has completed an analysis of the different Types of Bills that are valid under the OPPS which include 13x, 14x, 34x, 72x, 74x, 75x and 85x. Some of the Types of Bills such as 34x and 85x are included primarily for Medicare crossover claims – not for regular FFS business. For CAH – bill using type of bill13x and only use 85x when billing for Medicare/dual eligible claims. MDCH's system will crosswalk the 85x to a 13x for purposes of grouping/pricing editing. MDCH will also be implementing a new informational edit for invalid Type of Bill . Edit 638 will be implemented in the next couple of weeks to be informational only to prepare providers for billing only valid OPPS type of bills. Once OPPS is implemented, this edit will reject the claim if an invalid Type of Bill is submitted for an OPH claim.

Questions:

1) Ambulance provider and also have OPH PT40 in existence – do they have to re-enroll? MDCH is still finalizing the details regarding the Ambulance providers who are currently enrolled as a PT18 and the changeover to bill under OPPS. MDCH is working with our internal Provider Enrollment area to finalize the details and make the transition as easy as possible for providers.

2) Regarding multiple Dates of Service on one Outpatient Claim – please clarify the policy statement. Current MDCH processing for OPH only allows a single DOS on a claim. Under the proposed OPPS, providers can bill a single claim which spans across several days and a Service Line DOS is required. The Outpatient Code Editor(OCE) software will look at the span dates and the service line DOS and identify which lines apply to a single DOS and will group/edit/price according to an individual day.

3) Clarification regarding patient. in OPH on 9/30/06 that spans over to 10/1/06…. What is the effective date for the OPPS? MDCH will be using the 'From" date on the claim to determine whether it will fall into the old reimbursement/billing methodology or under the new OPPS methodology. Providers should bill any stay that begins/has a "From" date of 9/30/06 under the old methodology.

4) Dialysis services in the OPH setting when not a Dialysis provider? Under OPPS, there are specific codes for one time only dialysis services provided in the OPH setting (90935, 90945 – pay status S & 90940 – pay status N) and MDCH will recognize these services and allow OPH providers to bill.

5) Question regarding a claim with only packaged services on the lines versus incidental only – which ones pay $0 and which ones reject? OCE Edit 27 – Only Incidental Services Reported (entire claim rejection) only sets when all of the following are true: a) The claim has at least one HCPC code, and b) the claim has no fee schedule items, and c) the claim has no HCPCs code eligible for assignment to any APC, and d) none of the line items on the claim are denied or rejected. If any one of the following statements are true, OCE 27 does not set and the incidental line will "pay/approve" $0.

6) Question regarding education classes (diabetic/childbirth education) – Rev code 942 is considered packaged and will not pay under APCs?? Clarification that under OPPS, the payment is driven off of the

procedure code – so if billing for the procedure code for education/training – it will/should follow the pay status indicator of the HCPC.

7) Further discussion with payers regarding setting up their systems and identifying how to figure out what will/will not pay. Look to the pay status indicator for the HCPCs primarily rather than to Rev Code. OPPS is driven primarily by the HCPCs – not the Rev Code as our current Medicaid methodology is. MDCH has primarily identified the Wrap around codes through looking at the paid claims data output through the APC software/grouper/pricer/editor. Payers should also be looking to do the same by running claims through their software once it is set up to identify systems issues and differences in editing/reimbursement and payment logic.

8) Observation Room policy update – at this point in time MDCH is still reviewing information, comments and feedback from providers and Health Plans regarding Observation room coverage/payment . MDCH is still trying to determine the financial impact of implementing an authorization based observation room coverage and are anticipating that the policy will be in place prior to the OPPS implementation.

9) Further discussion, clarification of the repetitive billing issues under Medicare's OPPS – ie, dialysis, therapies, chemo, etc. Bronson offered to forward documentation/clarification regarding repetitive billing issues from Medicare. Certain services can be billed across multiple DOS (chemo/infusion) – but Medicare does define certain services that must be repetitive billed. Providers should also reference the Medicare billing manual for more information.

10) Discussion regarding DME/implantable devices (cochlear implants, vagal nerve stimulators) and coverage/payment under OPPS. Currently Medicaid pays cost to charge on these items under Rev Code 278. Under OPPS, MDCH believes these codes are payable and typically pay under an APC. If providers have specific concerns, MDCH has requested that they send detailed code information/descriptions to the APC mailbox for further review/investigation and determination of policy clarifications. Did not identify any issues with these devices in the Q1 2005 FFS data that was analyzed and will keep an eye out for these in future data sets.

11) Question regarding false labor coverages under OPPS and frequency editing on these types of codes. Will MDCH continue with frequency editing on certain codes (ie false labor, childbirth education) or any other codes in general. MDCH intends to review all current frequency/occurrence, age, diagnosis, quantity, and gender parameters on OPH codes to determine if they can be lifted under the proposed OPPS.

12) Will Medicaid under it's proposed OPPS implement the 72 hour rule similar to Medicare's policy (any OPH service provided within 72 hours of an IPH stay will not be paid separately and must be included on the IPH claim). MDCH does not currently intend to follow the 72 hour rule and will stay with the policy that only ER visits that turn into IPH admissions must be billed on the IPH claim.

13) Hospitals inquiring if Medicare's OCE edits will be reflected on their rejected claims and if/how they can find these in advance of submitting the claim (like on their Medicare billing side). Other hospitals indicated that they will be sending their Medicaid claims through their Medicare claims/billing/scrubbers to check for edits prior to submission to MDCH.

14) Question if MDCH will be accepting/reading and utilizing submitted modifiers under the proposed OPPS. MDCH intends and fully expects providers to bill with the appropriate modifiers on all OPH claims as part of the implementation of the OPPS. Modifiers are critical to the processing, editing and payment of services under the OPPS.

15) For the conversion factor, is the factor going to be DOS specific or Date of Payment specific?? Ie, will MDCH make the conversion factor change retroactive or on a go forward basis and will the factor be DOS specific or by Date of Payment. Anything other than DOS specific would cause issues with either providers or MDCH having to adjust previously processed claims. To clarify, if the reduction factor is 58% initially and based on historical OPPS claims data paid thru Jan '07 MDCH determines the factor should be 62%, the 58% will remain in place for any DOS from 10/1/06 to 12/31/06 and the new reduction factor of 62% will be applicable for any DOS on/after 1/1/07 – regardless of when the claim was received/paid. This should eliminate providers/MDCH having to adjust claims and minimize MDCH's monitoring of claim volume, thresholds and charges when analyzing and making adjustments to the reduction factor. MDCH also intends to use the B2B testing data and the pilot process claims data to help estimate the initial reduction factor that will be used at implementation.

16) Question regarding Medicare's National Coverage Determinations/Local Medical Reviw Policies and the Advanced Beneficiary Notice. MDCH does not currently have any editing in place to follow Medicare's NCDs or LMRPs. It is not included in the APC software/OCE editing packages and is very complex to implement/mirror. MDCH is reviewing all current OPH codes with any kind of diagnosis, gender, age, frequency and quantity editing to follow as close to Medicare as possible while editing for appropriateness of services until NCD/LMRP editing capability is feasible. MDCH intends for providers to follow Medicare's NCD/LMRP guidelines/requirements and will be monitoring and reviewing claims on a post payment basis. Providers can/should follow Medicare's NCD/LMRPs in conjunction with MDCH's Wrap Around codes list in order to determine non-covered services. Medicaid policy regarding non-covered services was re-iterated to indicate that the ABN/written documentation should be obtained from the beneficiary indicating that they have been notified that the service is non-covered.

IV. Operational & Implementation Issues – Karen Scott:

B2B testing - Instructions were shared with the workgroup regarding MDCH's B2B testing for OPPS. MDCH is currently working on migrating the APC software into the B2B environment and hopes to be ready by mid May to accept test files. Providers who currently submit test files will not receive any APC pricing/editing on their results files. Once migrated, Providers will receive an 835 response which will reflect APC/OPPS payments, but no APC grouping information will be included. If providers wish to submit their test files before the migration is complete, they may do so and MDCH will hold onto their files and re-process them once the migration is complete – PROVIDED that they submit the required e-mail notifications to MDCH alerting them that a file has been sent. MDCH will send out a notification via the APC project mailbox when the systems migration and testing is complete and we are ready to begin B2B testing.

Note: Testing for the 835 modifications is still in the early stages and may not be in place even for implementation on 10/1/06. MDCH is encouraging providers to work with their service bureaus to submit these test files and the service bureaus will be the ones receiving the 835 in return by default if the hospital is not set up currently to receive the 835 on their live claims.

Some providers indicated that their service bureaus are refusing to forward on test files. MDCH will have some communications with service bureaus to encourage them to submit the test files, but ultimately, it is up to the hospitals and service bureaus to work out the issues for implementation/testing.

B2B test files should be for claims on/after DOS 1/1/06 billed as they would be under Medicare's OPPS billing guidelines. These test files will also be used as part of the impact analysis to compare OPPS reimbursement to the current payment methodology. Please include both FFS and dual eligible/Medicare claims in your test data files and initially, only submit 100 or less claims per test file. Once providers have successfully submitted a test file and MDCH has had some time to work out B2B and systems issues, then it is anticipated that larger files may be sent.

Medicare/Other Ins Claims – Claim vs Line level Payment Detail

MDCH is no longer going to pursue having providers report Medicare/OI payments on a line by line basis for purposes of calculating line level reimbursement. Hospitals have indicated that this would be a highly manual process to report line level payments/information on their secondary claim and would prefer to stay with the current methodology. Therefore, MDCH will stay with it's current 'roll down' methodology whereby the total Medicare/OI payment is compared to the MDCH payment in total to determine any MDCH liability for the claim. If any MDCH payment is due – the Medicare payment is prorated across each individual approved line, compared to the MDCH fee screen, and if any amount is due by MDCH, payment is made – up to the co-ins/ded amounts in total for the claim. This methodology will remain in place until such time that line by line payment reporting can be accommodated in the crossover claims process or through some other means. Under the proposed OPPS, any payment amounts will be applied on approved APC or fee schedule lines (up to the total line charge for fee schedule items) and will not be applied to packaged service lines.

V. Meeting wrap up/adjournment